Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior

ABSTRACT

These guidelines review what is known about the epidemiology, causes, management, and prevention of suicide and attempted suicide in young people. Detailed guidelines are provided concerning the assessment and emergency management of the children and adolescents who present with suicidal behavior. The guidelines also present suggestions on how the clinician may interface with the community. Crisis hotlines, method restriction, educational programs, and screening/case-finding suicide prevention strategies are examined, and the clinician is advised on media counseling. Intervention in the community after a suicide, minimization of suicide contagion or imitation, and the training of primary care physicians and other gatekeepers to recognize and refer the potentially suicidal child and adolescent are discussed. *J. Am. Acad. Child Adolesc. Psychiatry*, 2001, 40(4):495–499. **Key Words:** suicide, suicide attempts, practice guidelines, suicide prevention, suicidal ideation, mood disorders.

Suicidal behavior is a matter of great concern for clinicians who deal with the mental health problems of children and adolescents. The incidence of suicide attempts reaches a peak during the mid-adolescent years, and mortality from suicide, which increases steadily through the teen years, is the third leading cause of death at that age. Clinicians need to know how to identify those at greatest risk for suicide from among the large number of suicide attempters who have a benign prognosis; how to provide treatment for the suicidal patient; how to advise and counsel the child, adolescent, and parental survivors of individual suicides; and how to provide expert consultation to educational and public health authorities on appropriate and inappropriate directions for suicide prevention programs. The parameters were written to aid clinicians in the assessment and treatment of children and adolescents exhibiting suicidal behavior or harboring suicidal ideation.

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This summary and the full text of the Practice Parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior are available to Academy members on the World Wide Web (www.aacap.org) and will appear in a future supplement to this Journal. The full text of these parameters was reviewed at the 1999 Annual Meeting of the American Academy of Child and Adolescent Psychiatry. The full text was approved by AACAP Council on October 17, 2000.

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EXECUTIVE SUMMARY

This summary provides an overview of the assessment and treatment recommendations contained in the Practice Parameters for the Assessment and Treatment of Children and Adolescents With Suicidal Behavior. This summary includes many of the most important points and recommendations from these practice guidelines. However, the treatment and assessment of suicidal patients requires the consideration of many important factors that cannot be conveyed fully in a summary, and the reader is encouraged to review the entire document. Each recommendation in the executive summary is identified as falling into one of the following categories of endorsement, indicated by an abbreviation in brackets following the statement. These categories indicate the degree of importance or certainty of each recommendation.

"Minimal Standards" [MS] are recommendations that are based on substantial empirical evidence (such as well-controlled, double-blind trials) or overwhelming clinical consensus. Minimal standards are expected to apply more than 95% of the time, i.e., in almost all cases. When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

"Clinical Guidelines" [CG] are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75% of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

"Options" [OP] are practices that are acceptable but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be the perfect thing to do,

but in other cases they should be avoided. If possible, the practice parameters will explain the pros and cons of these options.

"Not Endorsed" [NE] refers to practices that are known to be ineffective or contraindicated.

SUICIDE

Suicide, exceedingly rare before puberty, becomes increasingly frequent through adolescence. Approximately 2,000 U.S. adolescents commit suicide each year.

The factors that predispose to completed suicide are many and include preexisting psychiatric disorders and both biological and social-psychological facilitating factors. The overwhelming proportion of adolescents who commit suicide (more than 90%) suffered from an associated psychiatric disorder at the time of their death. More than half had suffered from a psychiatric disorder for at least 2 years.

Stress events often precede adolescents' suicides, including a loss of a romantic relationship, disciplinary troubles in school or with the law, or academic or family difficulties. These stresses may ensue from the underlying mental disorder itself (e.g., trouble with the law) or they may be normative outcomes of uncontrollable events (e.g., a death in the family) with which the adolescent with a mental disorder may not be able to cope. An adolescent with an underlying mental disorder may be faced with a greater number of stressful events than the average adolescent. Or he may perceive the events that occur as more stressful.

Suicide is much more common in adolescent and young adult males than females (the ratio grows from 3:1 in the rare prepubertal suicides to approximately 5.5:1 in 15- to 24-year-olds), but many of the risk factors are the same for both sexes. Mood disorders, poor parent–child communication, and a previous suicide attempt are risk factors for suicide in both boys and girls, although a previous suicide attempt is more predictive in males. Substance and/or alcohol abuse significantly increase the risk of suicide in teenagers aged 16 and older. Family pathology and a history of family suicidal behavior may also increase risk and should be investigated.

African Americans currently have a lower rate of suicide than whites, but the suicide rate of African-American adolescent and young adult males has been rising rapidly. Native American and Alaskan Native youth have historically had a very high rate of suicide. Attempted suicide rates of Hispanic youth are greater than those of white and African-American youth. Clinicians should consider the cultural background of a suicidal youth and assess cultural attitudes in the child's community. However, ethnic differences in the suicide rate may reflect contagion in isolated groups rather than cultural differences.

SUICIDAL IDEATION

Suicidal thoughts are common in children and adolescents of both genders and are by no means always associated with other features of psychopathology. They usually come to clinical attention when enunciated as threats.

Disruptive disorders increase the risk of suicidal ideation in children 12 years old and younger, and substance use or separation anxiety may provoke adolescent ideators of both sexes to attempt suicide. Mood and anxiety disorders increase the risk of suicidal ideation. Panic attacks are a risk factor for ideation or attempt in females, while aggressiveness increases the risk of suicidal ideation or attempt in males. Adolescent suicide attempters may differ from ideators in having more severe or enduring hopelessness, isolation, suicidal ideation, and reluctance to discuss suicidal thoughts.

ATTEMPTED SUICIDE

Mood disorders (particularly early-onset major depressive disorder), anxiety disorders, substance abuse, and runaway behavior independently increase the risk of suicide attempts in both sexes. Suicide attempts are more common in girls than boys (approximately 1.6:1).

Suicide attempts are considerably less common than suicidal ideas, but they are the presenting complaint in a sizable proportion of adolescents referred to mental health professionals. It is estimated that each year, approximately 2 million U.S. adolescents attempt suicide, and almost 700,000 receive medical attention for their attempt.

Teen suicide attempters are much more likely than those who only ideate to have associated psychopathology, especially a mood disorder, but the attempts often occur in the context of a relatively brief adjustment reaction.

Having made a previous suicide attempt greatly increases the risk of a boy's eventually committing suicide, but the predictive effect in females is less substantial. Only half of all suicide completers have made a known suicide attempt before their death; however, our information on previous attempts remains incomplete, as many attempts go unreported. Gay, lesbian, and bisexual youth are at increased risk for suicide attempts, often having multiple risk factors (i.e., depression, prior suicide attempts, substance abuse, sexual victimization, family conflict, and ostracism at school), as are adolescents who have been victims of childhood sexual or physical abuse.

Even the most skilled clinician can find it difficult to differentiate between benign and ominous suicidal behavior. Many adolescents who have made a medically serious attempt will never do so again, while others who have made what seemed like only a mild "gesture" may eventually commit suicide. The term *gesture* used by some clinicians to denote a nonlethal, self-destructive action that is deemed a cry for help or a manipulation without serious intent, is therefore misleading, because it minimizes the potential risk for future suicidal behavior. One cannot gauge future suicidal behavior. However, research has provided some broad indicators about risk factors and the assessment of attempters (Tables 1 and 2) that need to be considered by all clinicians [MS].

TABLE 1
High-Risk Factors for Suicide in Adolescents

Males at much higher risk than females
Among males
Previous suicide attempts
Age 16 or older
Associated mood disorder
Associated substance abuse
Among females
Mood disorders
Previous suicide attempts
Immediate risk predicted by agitation and major depressive disorder

ASSESSMENT

Assessment of suicidal patients requires an evaluation of the suicidal behavior and determination of risk for death or repetition, as well as an assessment of the underlying diagnoses or promoting factors.

Identification of Risk

Clinicians should be aware of which adolescent suicide attempters are at greatest risk for later suicide (Table 2) [MS]. These are older (16- to 19-year-old) male adolescents or adolescents of either gender, regardless of age, with a current mental disorder or disordered mental state, such as depression, mania or hypomania, or mixed states, especially when complicated by comorbid substance abuse, irritability, agitation, or psychosis. Attempters who have made prior suicide attempts, those who used a method other than ingestion or superficial cutting, and those who still want to die are also at higher risk.

Clinicians should ascertain the suicidality of depressed adolescents (i.e., whether and how often they think about suicide and whether they have ever attempted suicide). If suicidal ideation or recent suicidal behavior is present in a depressed teenager, he or she should continue to be monitored [MS].

Assessment information should always be drawn from several sources, including child or adolescent, parents or guardians, school reports, and any other individuals close to the child. Structured or semistructured suicide scale questionnaires, whether delivered by the clinician or self-completed by the child or adolescent, have limited predictive value. They may complement but should never take the place of a thorough assessment or substitute for any aspect of assessment.

TREATMENT

Treatment must encompass the acute management of suicidal behavior as well as treatment of associated mental disorders.

Acute Management

Emergency room and other crisis staff should establish a relationship with the suicidal individual and family and establish the importance of treatment [MS].

TABLE 2
Checklist for Assessing Child or Adolescent Suicide Attempters in an Emergency Room or Crisis Center

Attempters at Greatest Risk for Suicide
Suicidal history
Still thinking of suicide
Have made a prior suicide attempt
Demographics
Male
Live alone
Mental state
Depressed, manic, hypomanic, severely anxious, or have a mixture of these states
Substance abuse alone or in association with a mood disorder
Irritable, agitated, threatening violence to others, delusional, or hallucinating
Do not discharge such a patient without a psychiatric evaluation.
Look for signs of clinical depression
Depressed mood most of the time
Loss of interest or pleasure in usual activities
Weight loss or gain
Can't sleep or sleeps too much
Restless or slowed-down
Fatigue, loss of energy
Feels worthless or guilty
Low self-esteem, disappointed with self
Feels hopeless about future
Can't concentrate, indecisive
Recurring thoughts of death
Irritable, upset by little things
Look for signs of mania or hypomania
Depressed mood most of the time
Elated, expansive, or irritable mood
Inflated self-esteem, grandiosity
Decreased need for sleep
More talkative than usual, pressured speech
Racing thoughts
Abrupt topic changes when talking
Distractible
Excessive participation in multiple activities
Agitated or restless
Hypersexual, spends foolishly, uninhibited remarks

Source: American Foundation for Suicide Prevention (1999), Today's suicide attempter could be tomorrow's suicide (poster). New York: American Foundation for Suicide Prevention, 1-888-333-AFSP.

Although there have been no randomized controlled trials to determine whether hospitalizing high-risk suicide attempters saves lives, clinicians should be prepared to admit suicide attempters who express a persistent wish to die or who have a clearly abnormal mental state [MS]. Inpatient treatment should continue until the mental state or level of suicidality has stabilized [MS].

Regardless of the apparent mildness of the patient's suicidal behavior, the clinician must obtain information from a third party. Discharge can be considered if the clinician is satisfied

that adequate supervision and support will be available over the next few days and if a responsible adult has agreed to "sanitize" the environment by securing or disposing of potentially lethal medications and firearms [MS].

The most common method used by adolescents to commit suicide in the United States is with a firearm. Ingestion of medication is the most common method adolescents use to attempt suicide. Availability and presence in the home of firearms and lethal medication must be determined during assessment, and parents must be explicitly told to remove firearms and lethal medication [MS]. It is valuable for the clinician to warn the adolescent (and the parents) about the dangerous disinhibiting effects of alcohol and other drugs [CG].

The value of "no-suicide contracts," in which the child or adolescent agrees not to engage in self-harming behavior and to tell an adult if he or she is having suicidal urges, is not known. The child or adolescent might not be in a mental state to accept or understand the contract, and both family and clinician should know not to relax their vigilance just because a contract has been signed.

If possible, an appointment should be scheduled for the child or adolescent to be seen for a fuller evaluation before discharge from the emergency room. If this is not possible, a telephone contact for parent or other caretaker should be obtained and a procedure set up clinical staff, if they have not been contacted by the parent with in a reasonable period of time, to themselves initiate the contact [MS].

The clinician treating the suicidal child or adolescent during the days following an attempt should be available to the patient and family (for example, receive and make telephone calls outside of therapeutic hours) or have adequate physician coverage if away [MS], have experience managing suicidal crises [MS], and have support available for himself or herself [CG].

Once a therapeutic alliance is established and the adolescent attends the first treatment sessions, he or she is more likely to continue treatment.

Psychotherapies

Psychotherapy, an important component of treatment for the mental disorders associated with suicidal behavior, should be tailored to a child's or adolescent's particular need [MS]. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT-A), dialectical behavioral therapy (DBT), psychodynamic therapy, and family therapy are all options [OP].

Psychopharmacology

As with psychotherapies, psychopharmacology to treat suicidal behavior should be tailored to a child or adolescent's placement-specific needs. Lithium greatly reduces the rate of both suicides and suicide attempts in adults with bipolar disorder. Discontinuing lithium treatment in bipolar patients is associated with an increase in suicide morbidity and mortality.

Selective serotonin reuptake inhibitors (SSRIs) reduce suicidal ideation and suicide attempts in nondepressed adults with cluster B personality disorders. They are safe in children and adolescents, have low lethality, and are effective in treating depression in nonsuicidal children and adolescents. There have been some reports that SSRIs may have a disinhibiting effect (especially in patients with SSRI-induced akathisia) and increase suicidal ideation in a small number of adults not previously suicidal. Further controlled research is necessary to determine whether there is an association in children and adolescents. However, it would be prudent to carefully monitor children and adolescents on SSRIs to ensure that new suicidal ideation or akathisia are noted [MS].

Tricyclic antidepressants should not be prescribed for the suicidal child or adolescent as a first line of treatment [NE]. They are potentially lethal, because of the small difference between therapeutic and toxic levels of the drug, and have not been proven effective in children or adolescents.

Other medications that may increase disinhibition or impulsivity, such as the benzodiazepines and phenobarbital, should be prescribed with caution [OP]. Any and all medications prescribed to the suicidal child or adolescent must be carefully monitored by a third party, and any change of behavior or side effects must be reported immediately [MS].

PREVENTION

Public health approaches to suicide prevention have targeted the suicidal child or adolescent, the adults who interact with them, their friends, pediatricians, and the media.

Teenagers may be made aware of the existence of crisis hotlines [OP]. Although widely used, early studies, hampered by methodological deficiencies, failed to show that hotlines reduce the incidence of suicide. But it would be wise to assume that their value remains untested. Research has uncovered some hotline deficiencies, but new studies are needed to determine whether correcting these problems can increase their effectiveness.

Public health measures, such as restricting young people's access to firearms, may result in a short-term reduction in the rates of suicide, but there is not yet evidence that this effect would be lasting [OP]. Raising the minimum legal drinking age for young adults appears to reduce the suicide rate in the affected age group.

Suicide awareness programs in schools frequently minimize the role of mental illness and, although designed to encourage self-disclosure by students or third-party disclosure by their friends, have not been shown to be effective either in reducing suicidal behavior or increasing help-seeking behavior.

Because curriculum-based suicide awareness programs disturb some high-risk students, a safer approach might be to focus on the clinical characteristics of depression or other mental illnesses that predispose to suicidality. In the absence of evidence to the contrary, talks and lectures about suicide to groups of children

and adolescents drawn from regular classes should be discouraged [NE]. This is because of their propensity to activate suicidal ideation in disturbed adolescents whose identity is not usually known to the instructor. Screening or suicide education programs for teenagers that do not include procedures to evaluate and refer identified ideators or attempters are not endorsed [NE]. Direct screening programs may identify those with underlying risk factors to a clinician for further evaluation [OP].

Primary practitioners, counselors, or others who may lack the time, resources, or training to evaluate a child's or teenager's mental state should make use of self-completion questionnaires to screen in their office for depression, suicidal preoccupations, and previous suicidal behavior [CG]. There is ample evidence that teenagers in mid to late adolescence—the group that is at greatest risk for suicide attempt and completion—will, if asked directly, reveal this information. This practice can be especially recommended to family practitioners, pediatricians, school counselors, juvenile justice professionals, and psychologists who wish to survey their populations for teenagers at high risk for suicide. Those identified as being at risk should be referred for further evaluation and treatment, if necessary, and should receive support and follow-up (i.e., telephone calls, case manager if available) during the transition period.

Clinicians engaged in public health practice should be able to advise media reporters and editors on the dangers of excessive coverage of individual suicides [OP].

Finally, primary care physicians and gatekeepers should be trained to recognize risk factors for suicide and suicidal behavior and, when necessary, refer to a mental health clinician [CG].

POSTVENTION

After a suicide, the relatives, friends, and teachers of the child or adolescent who committed suicide may benefit from intervention to facilitate grieving, reduce guilt and depression, and decrease the effects of guilt and trauma. There may also be a call to intervene to minimize the risk of imitative or copycat suicides, but there is no agreement about how this should be done [CG].

REFERENCE

American Academy of Child and Adolescent Psychiatry (in press), Practice parameters for the assessment and treatment of children and adolescents with suicidal behavior. *J Am Acad Child Adolesc Psychiatry*